



Provider Reference Manual

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Proud members of and associated with the (OMA) Office Managers Association.

Introduction

What is 4-Most?

- A product of Physician Services, LC.
- A statewide network of physicians, hospitals and ancillary providers who provide claims payors with contracted discounted fees, and physicians with patient volume.
- Contracted Network of over 2500 physicians and ancillary providers, and 60 hospitals/facilities servicing all 55 counties of West Virginia and bordering states.
- Contracted network to Third Party Administrator's (TPA's), Insurance Companies and self funded employer groups.

- Our network is attached to PPO plan designs, not restrictive HMO plan designs.

Mission:

"Our mission is to develop and maintain the most accessible, cost effective network of quality healthcare providers

Operational Guidelines

Billing Procedures:

Claim forms must be completed in their entirety. The accuracy in which the claim form is completed directly effects the efficiency in which the claim is processed for payment. Line items left blank on the HCFA can result in the claim being returned to the provider, therefore, **delaying payment**.

- All claims should be submitted to the address listed on the individual member's identification card.
- Claims submitted without the following specific items will greatly delay payment as the claim will be returned:
 - Employer name
 - Group name
 - Group number - "If present on ID card"
- At the time of service, "PLEASE DO NOT COLLECT" any amounts other than the patient's co-payments.
- Members may not be billed for any amounts other than co-payments and deductibles, until after the provider receives the explanation of benefits (EOB) from the payor.
- It is required that all claims be submitted with accurate and **current CPT-4, HCPC's as well as ICD-9 codes**. For each procedure listed on the claim a diagnosis code must support the services to ensure expeditious and accurate processing of the claim.

Referrals, Pre-Admission Certification & Utilization Review

Referrals:

**A written referral or authorization number is not necessary when referring to another participating physician in the 4-Most Health Network. The benefits, however, may differ if not referred to a participating physician or hospital. Please refer to our Provider Directory or our website; www.4mosthealth.com for a complete listing of the participating providers.

Pre-Admission Certification and Utilization Review:

**We do not provide Utilization Review on pre-admission review services. If pre-admission or pre-certification is a part of your benefit plan, a telephone number will be denoted on the ID card as to where you need to call for pre-admission certification. It is the office staff responsibility to pay close attention to the individual members Identification card for the appropriate telephone number to call for pre-admission certification and utilization review of benefits.

Important Definitions

Co-Insurance:

**Co-insurance is a provision of each benefit plan by which the participant shares in the cost of various covered services on a percentage or flat rate basis. These too will vary by benefit plan. The benefit plan will pay their percentage of the maximum allowable or flat rate amount set forth in the negotiated fee schedule, the participant will be responsible for the remaining amount up to the stated maximum allowable, (ie: benefit plan pays 80%, the participant pays 20%).

· Because appropriate discounts are not applied to the claim until it is adjudicated, **do not collect the co-insurance amount until the final explanation of benefits (EOB) has been received and reviewed for the correct remittance amount.** No amounts, other than co-pays and/or deductibles should be collected in advance.

Co-payments:

**Co-payments are generally fixed amounts rather than a percentage and are due at the time the services are rendered. Co-payment amounts are most often found on the participant's ID card. These amounts will vary depending on the individual plan. It is recommended that a copy of each member's card be made at the time of each visit.

Deductibles:

**The amount of covered charges that the Insured Person must pay each calendar year before the policy pays major benefits.

Allowed Amount:

** The allowed amount is the contracted amount allowed after the PPO discount is subtracted from the total billed amount. The difference between the billed amount and the allowed amount must be adjusted off.

Claims Repricing:

**Claims are sent to 4-MOST to apply applicable PPO discounts for in-network providers. Claims are then forwarded to the TPA or Insurance Company for processing of payment. There is a one to three day turn around time on the claims; from the time 4-MOST receives the claims to the time 4-MOST mails the claims to the appropriate payor for adjudication.

Third Party Administrator (TPA):

**An organization hired by certain employers to facilitate benefit plan determinations and

processing of benefit plan claims. TPA's do not assume the financial risk or liability of making such benefit plan payments only the remittance of benefits upon final approval of the employer. TPA's & employers partner with managed care organizations, like PPO's, to obtain provider discounts and to assist in controlling health care quality and total plan cost.

Insurance Carrier:

**An organization that sells insurance contracts to certain individuals and employers, whereby the insurance carrier assumes the full financial risk and liability of making benefit plan determinations, processing of such benefit plan claims and the remittance of benefit plan payments. The individual and employer purchasing such insurance contracts have no approval or denial abilities of actual benefit payments or the decision affecting such payments. Insurance carriers also partner with managed care organizations, like PPO's, to obtain provider discounts and to assist in controlling health care quality and total plan cost. Insurance companies can also act as claims administrators only, when they act in this fashion they are referred to as ASO accounts or Administrative Services only.

Explanation of Benefits (EOB):

An explanation of benefits (EOB) will be issued to the physician each time services are submitted to a contracted claims administrator and benefit plan and reimbursements are assigned to the physician. This statement will identify the participant, date of service, procedure(s) performed, amount charged, allowable amount, percentage of coverage, applicable co-payments/co-insurance and deductibles applied, and the patient's financial responsibility. **Please Note: you may "not" collect the difference between your charged amount and the maximum allowable from the participant. This is the contracted discount.

Coordination of Benefits:

When a participant has two benefit plans covering services provided, benefits are coordinated to potentially pay 100% of covered charges. You or your staff should contact the claims administrator directly in order to verify the rules used to determine the order of benefit payment. **Please note: if the 4-MOST contracted payor is not the primary payor, then reimbursement to participating providers from 4-MOST contracted payor shall not exceed the amount allowed by the 4-Most Integrated Health Network fee schedule.

Credentialing

The initial credentialing process includes:

- Physician application to be completed in its entirety
- Copies of (and verification of)
 1. Licensure(s)
 2. DEA Registration
 3. Malpractice (face sheet from physician's liability policy)
 4. Degree
 5. Board Certification - if not board certified, verification of residency training
- Hospital Privileges
- Work history

As documents from any of these areas expire, it is "imperative" that we receive the updated information as quickly as possible.

Recredentialing

4-Most Health Network recredentials all providers in the network, Primary Care Physicians, Obstetricians/Gynecologist, and Specialists at least every two years. The recredentialing process includes verification of:

- Licensure(s)
- Valid DEA
- Board Certification
- Current, adequate malpractice insurance
- Professional liability claims history
- Application
- Hospital Privileges

Standards for Participation

To become a 4-Most Health Network provider, 4-MOST must then assess the need in the requested geographic location, if this assessment shows a need, provider will be sent a credentialing applications and participation agreement. Physician must be credentialed and meet the standards of participation as developed by 4-Most in association with participating physicians. A physician must have the following credentials.

- Drug Enforcement Administration (DEA) registration number if the scope of practice would warrant the physician to have a DEA
 - Professional Liability - minimum amount of \$1 million per occurrence, \$3 million aggregate
 - Admitting Privileges at a participating hospital
 - Clear report from the National Data Bank
 - Board Certified or Board Eligible, if not Board Certified or Board Eligible, the physician must demonstrate appropriate training for specialty listed
 - Proof of medical license
 - Sufficient information concerning any malpractice actions pending or resolved in the last 5 years
 - Completed confidential questionnaire
 - Signed and dated provider agreement
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Telephone Directory

Toll free number : 888-258-6477
Local: 304-776-0500
Fax: 304-776-1914

Specific Departments & Extensions

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